

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/06/2015
NAME OF PROVIDER OR SUPPLIER FAYETTE REGIONAL HEALTH SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 1941 VIRGINIA AVE CONNERSVILLE, IN 47331		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00168903 Unsubstantiated; lack of sufficient evidence.</p> <p>Facility Number: 005059</p> <p>Date of Survey: 7/6/15</p> <p>Fayette Regional Health System is in compliance with 410 IAC 15-1.5-5, Medical Staff/Physician Services, Indiana Hospital Licensure Rules.</p> <p>QA: cjl 07/30/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE